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THE LONG-TERM CARE SYSTEM IN DENMARK

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Table of Contents

List of Figures and Tables

1 The long-term care system

1.1 Overview

Philosophy and objectives

In general social care systems in European Member States can be grouped into three categories:

- the state responsibility model,
- the family care model and
- the subsidiary model.

The state responsibility model is characteristic for the Scandinavian countries and therefore also for Denmark (CESEP 2007). From the point of view of the population is in particular personal care primarily the task of the state (municipality). Nevertheless, a great part of help with practical duties (garden, financial tasks etc) is provided by members of the family, too. In Denmark long-term care falls under social care and is the responsibility of the local councils, as regards both provision and financing. The rules on long-term care are part of the Consolidation Act on Social Services (CASS). Local authorities provide care for the elderly based on the general principle of free and equal access to the assistance offered. They finance the costs of long-term care through local taxes and block grants from the state.

Denmark's overall objective for long-term care policy calls for services to be based on the older person's wants and needs (NAP 2003:40). As far as possible, this approach should ensure continuity in older people's live even if they become ill and inform. Older people in need of personal assistance and care will be offered help. Assistance is considered as help to recipients to help themselves, i.e. as supplementary assistance for tasks the recipient is unable to perform him- or herself. Furthermore, assistance aims at activation, its starting point being to enable the recipient to the widest extent possible to help perform as many tasks as possible (NSR 2006:41).

Available services

The various forms of long-term care services offered under Danish legislation include care in conventional nursing homes (care homes), in modern close-care accommodations (subsidised housing for older people with care facilities and associated care staff) and at home. In modern close-care accommodations housing areas are separated from care services areas. Residents have to pay a monthly rent corresponding to the costs of running the housing estate, but they have access to receive benefits depending on income.

Home help can be granted as temporary or permanent assistance. Temporary assistance may be charged (free only for people with the lowest income), but permanent personal and practical assistance is free. Nevertheless, local councils may charge payments for expenses that are not staff expenses (for example laundry coins, meal arrangements).

Eligibility criteria

Any person who is lawfully resident in Denmark is entitled to assistance under the Consolidation Act on Social Services. They are eligible to receive personal care and help with practical duties, irrespective of age, income or wealth. There are no minimum requirements in impairments to receive personal and practical help. After an individual assessment the help needed will be provided, even if the required time for help is less than 2 hours per week.

Funding

Permanent home help is free of charge, temporary home help have to be financed by the recipients and clients in nursing homes have to pay rents depending on income. They are in general not high. Long-term care as a part of social assistance will be financed by local taxes and block grants from the state.

Beneficiaries

In 2007 around 206,600 people received personal and practical help. This was 3.8% of the population. 87% of the beneficiaries were 65 years old and older. The share of the oldest old (80+) was 56%. Most of the recipients live in their own home (80%), and 20% in nursing homes or nursing dwellings. Around 44% of people living in their own home receive solely help with practical duties.

1.2 Assessment of needs

The municipal council shall offer personal care and assistance and assistance or support for necessary practical work at home. The assistance shall be offered to persons who are unable to carry out the said activities due to temporary or permanent impairment of physical or mental function or special social problems (CASS, 16, 83 (1) and (2)). Latter can be used as definition of need of care.

Personal and practical assistance is granted following a concrete and individual assessment of the recipient's functional abilities and needs based on local council's adopted service level. Denmark has adopted a comprehensive system of assessment and client management for elderly persons living in the community. Since 1996, everyone aged 75 and older are entitled to at least two preventive visits annually from a case manager employed by the municipality in order to evaluate individual needs, and assist with planning for independent living. The Danish Ministry of Social Affairs introduced the municipalities to organise preventive home visits to older people, but did not command specific guidelines on how to carry out the visits. Thus, great variation between the municipalities of how the law was managed and implemented exist (Vass et al. 2007). In general, assessments have to be multidimensional and have to comprise all aspects of the individual's well-being, i.e. functional ability, welfare, life content, home conditions and possibilities of self-determination, but also include review of medication, rehabilitative support, visitation and referral to specialist or other health care professionals if needed. For the assessment of functional impairments the Barthel index is used.

In 2007, visits are primarily carried out by district nurses, but several other primary care professionals, e.g. occupational therapists, physiotherapists, and social workers are also engaged

in the scheme. In a survey regarding the quality of care carried out by Rostgaard (2008) in 14 municipalities in Denmark in 2006/2007 also care assessors were interviewed. All interviewed care assessors had obtained a formal assessment degree, usually consisting of a two weeks course in assessment. They had on average been working within the care sector for 3.7 years, mostly as home carers before working with assessment.

Clients needing formal care are further assessed by a home care manager, and the resulting care plan ends up as a contractual specification for needed services. There exists no predefined classes of dependency, but the applicant will be classified in a continuum of dependency according his/her specific individual needs. If the client disagrees with this service allocation, it can be appealed. The municipal shall consider applications for assistance on a case-by-case basis, subject to an assessment of the assistance needed for the tasks that the applicant is unable to perform. In assessing the need for assistance, the municipal council shall consider all applications for assistance from the applicant (Consolidation Act on Social Services (CASS), Chapter 16, Section 88 (1)). The assistance shall be adapted from time to time to the specific needs of the recipient (CASS, 16, 88 (2)).

The municipal council shall prepare a plan containing information about the functions covered by the assistance, the object of the assistance, and the period during which assistance is to be provided. The plan shall be completed in cooperation with the applicant and will be returned to the applicant in connection with the decision (CASS, 16, 89 (2)). For nursing home residents the plan shall also include information about the overall program for the care and attendance to be provided to the applicant.

1.3 Available long-term care services

General

In general, all kinds of long-term care services are available free of charge, including nursing homes, personal home care and practical help. Personal home help and practical help will be provided for people in need for care living either in their own home or in nursing dwellings or special dwellings for the elderly. Since 2002 people are entitled to choice a private or public provider of practical assistance and since 2003 also of providers of personal care. In 2007, around 63% of municipalities provided free choice of practical assistance and 41% of personal care providers (Rostgaard 2007).

Which services?

Denmark has more than any other EU countries given explicit policy priority to community care over residential care, promoting older people's living in their own home. Therefore, relatively few older persons are in long-term care institutions compared to other EU countries. Since the law on dwellings for older people from 1987, no new nursing homes have been constructed, and instead a varied range of dwellings adapted for older persons have been developed. People in need for care living in their own home or in special dwellings for the elderly are eligible to receive home nursing, home care and practical help. Home nursing refers to the medically necessary treatments (e.g. injections, wound care) provided by professional nurses at home, usually as prescribed by a physician. Health services also include health promotion and rehabilitation services. Home help refers to personal care services (i.e. ADL assistance) and domestic tasks (e.g. shopping, meal preparation, cleaning) provided by a range of para-

professionals, including personal care workers, homemakers, and housekeepers (WHO 2003). Additional measures to activate people are provided.

Whereas informal care giving by relatives is not common, help for family care giver will be supported by the local authorities. Substitute or respite care will be offered as well as cash allowances for palliative care. Under specific circumstances a carer of a closely connected person can be employed by the municipality up to 6 months.

Who is eligible?

All citizens in Denmark are entitled to receive social services, irrespective of age, income, assets, living arrangement and potential of informal carers. The assistance will be provided on the basis of the recipient's particular needs and conditions and in consultation with the individual recipient. Eligibility for social care is decided by a special municipal service. There are no minimal requirements to receive benefits from the local community. Long-term care needs are assessed by home care managers. A special scheme exists for assessment and management of elderly people living in the community: people aged 75 and over receive two preventive visits a year from municipal case manager, who evaluates their needs and helps them plan for independent living. The assessment are mainly performed by nurses with input from home helpers but family doctors opinions may be asked for, occupational therapists may do home visits and physical therapists suggest training. Home-help workers and nurses coordinate their services and the home care team monitors the process (WHO 2007).

1.4 Management and organisation

In Denmark, the government is responsible for the legislation concerning social services and assistance, but the local authorities are responsible for providing social services and for their performance. As long- term care is a part of social assistance, the provision of personal care and help with practical duties will be organized and managed by the local authorities. The local council in the local authority is the body obliged to offer home care services as well as places in nursing homes, nursing dwellings or dwellings for the elderly. Nevertheless, they are not necessarily the provider of the required services.

Since 2003, elderly are entitled to choose freely between private and municipal providers of services and the local authorities are obliged to establish a framework for enabling private providers to enter the market for personal and practical assistance. According to the local government act, the local council must decide whether services should be tendered and, if so, which ones (Council of Europe 2008). The local council will lay down the framework within the providers are to solve the tasks. The prices are determined on the basis of the local authorities' provider's average long-term costs. The local authority must always impose quality requirements. The quality standards and price requirements for both public and private services must be adopted by the local authority which follows up on the quality and management of the services provided at least once a year. The quality standards must describe the services available at the local level to persons in need of assistance, physical rehabilitation or general physical exercise in order to ensure transparency and to enable the users to evaluate the performance of providers. Local authorities must make a clear distinction between their function as a local authority and their function as service providers and have to isolate the costs for home help services and make them transparent.

The local council is responsible for capacity planning and monitoring. The local authority must supervise the performance of the provision of personal and practical assistance to elderly people. In cases where private providers perform local authority tasks, the local council is also responsible for supervising the provider performing the task. As part of supervision, the local council must carry out inspection visits in care homes and similar dwellings at least twice a year and prepare an inspection report. One of the visits must be unannounced.

1.5 Integration of Long-term care

In general, health care and long- term care are public responsibilities. Whereas long-term care financing and providing is the responsibility of the local municipality, health services are financed, planned and operated by the counties. To ensure efficient and effective care giving and to coordinate health and long-term care a case management system has been introduced. Case management is a comprehensive and systematic process of assessing, planning, arranging, coordinating and monitoring multiple long-term care services for the individual client across time, setting and discipline (WHO 2003). Home nursing as well as personal care services is provided by home nurses. Practical help will be provided by home-help workers, housekeepers, volunteers. All service teams work closely together to coordinate their services, and ongoing care is regularly monitored by the home care team. Back-up consultations from the medical side of the system is often provided by hospital-based geriatricians or geriatric teams, particular when home care clients present complex problems or institutional placement is indicated. Even though health and social care appears to be fairly well integrated problems occur at the interface between regionally administrated hospitals and municipally administrated social care services.

2 Funding

The total public net expenditure on long-term care was 4.33 billion Euro (DKK 32.3 billion) in 2003 (Ministry of Social Affairs 2005, see also Table 1). Eurostat (2008) provides information based on the system of health accounts: In 2005 around 4,055 million Euros were spent on long-term care in Denmark. This was 1.95% of the GDP. Most of the amount was spent on home care (4,044 million), and only 11.2 million Euros on nursing homes. The lion’s share of social service costs is financed by local taxes, although the municipalities receive additional reimbursement by means of block grants, equalization grants, and temporary subsidies from the national government to promote the selective expansion of services. For example, since 2003, the Danish parliament has earmarked a total of 18.4 million Euro (DKK 137 million) for dementia initiatives (Council of Europe 2008:109).

User fees (for products and materials used in connection with permanent home help services) and rents (for institutional and housing services) are levied, but play only a minor role in the social service funding scheme. Figures on the average amount of such payments do not exist (Council of Europe 2008:108).

3 Demand and supply of LTC

According to the Consolidation Act on Social Services, all needs of personal care or help with practical duties are covered by the municipalities without minimum requirements. Local authorities have developed a wide range of services aimed at helping the elderly in need of care to help themselves. This includes assistance with cleaning, shopping, washing, preparing meals, and personal hygiene and care. People in need of care and help not receiving any assistance from the municipalities are rare. Thus, the number of people receiving practical and personal help may also be an indicator for the demand of care

The public sector is the major provider of long-term and home care for older people, but the government favours the development of competitive private agencies. Additionally, volunteer work will be supported (Council of Europe 2008). The perspective is to broaden the volunteer profile by integrating volunteer work into the senior citizen's daily life regardless of the volunteer's age, profession, or ethnic background (Jarden and Jarden 2002). People in need of care have the free choice of providers of home care services and the choice between the several kinds of residential accommodations. The free choice of nursing homes will be introduced soon.

3.1 Need for Long-term care

In 2007 some 5.5 million people lived in Demark[1]. Around 15%, that is to say 844 thousand inhabitants were 65 years old and older, and around 4% were 80 years old and older (225,000 people). Like in other European countries it is expected that the share of elderly will increase markedly in the future. In 2050 one quarter of the population is expected to be 65 years old and older (Figure 1). The share of the oldest old (80+) will rise from 4% to 9.7% by 2050. As the need of care is strongly related to age, it can be expected, that the need of care will also increase.

The need of care depends also on the living situation of the elderly. Singles have a possibility to need help from outside the household than persons living with a partner. Whereas the "young old" often have a partner (two thirds of the 65 to 69 years old persons have a partner), the share of people living alone rises sharply with age. Around 72% of the people aged 85 to 89 are singles (Figure 2). As in particular the number of the oldest old will increase the further development of need of care will show a high dynamic.

In general, it is hard to quantify the number of people in "need of care". But in Denmark all people in need of care are entitled to receive personal care and help with practical duties provided by the municipalities without minimum requirements. To ensure, that all people in need of care can receive the required help the instrument of "preventive home visits" was introduced. Every person aged 75 and older not receiving permanent home help are entitled to receive two preventive home visits per year. A case manager employed by the municipality visit the elderly (75+) to evaluate the individual needs and to draw up an individual care plan. But not all elderly (75+) agreed to be visited by a case manager. In 2007, 30% of preventive home

[1] Midyear population 2007.

visits were refused and in 45% of the cases completed preventive home visits were carried out.

After an assessment the required and in the assessment report stated amount and kind of help will be provided, independently of the living situation of the people in need of care or the potential help by partners living in the same household. Furthermore, Danish ageing policy is based on the idea that the type of housing should not decide the care and services available but only the individual's needs should determine the level of care needed and provided (Council of Europe 2008). Thus, the help will be provided irrespective of the living arrangement of the recipient either in their own home or in nursing homes or nursing dwellings. Therefore, the number of people receiving permanent home help can be used to get an idea about the number of people in need of care. In 2007 around 206,600 people received permanent home help.

The Ageing Working Group (AWG) carried out a new estimation of the development of long term care expenditure in the EU (EC/EPC 2009). To estimate the fraction of the elderly population who may need long term care services, they used disability rates (inability to perform one or more Activities in Daily Living). According to this estimation the number of dependent people accounts to 164,000 in 2007 and will rise to 327,000 by 2050 in Denmark. The estimation of the AWG is lower than the number of people receiving permanent home help in 2007.

3.2 Role of informal and formal care in LTC system

Denmark has made the choice for formal care over informal care. Public authorities play a significant role in the provision of all kinds of long-term care and as a consequence the family's contribution to provide in particular personal care for older people is regarded as negligible (Leeson 2004).

3.3 Demand and supply of informal care

Information about the demand of informal care as well as informal care giving activities and the characteristics of informal care givers is rare (Kröger 2005). Leeson (1999) carried out a survey elucidating the situation of older people aged 60 years and over in rural and urban areas in Denmark. Regarding this study less than 1 % of the interviewed elderly received personal help from their family members or other members of the social networks (Leeson 2004). Another study has found that up to 60% of Danish older people receive some form of help from relatives, friends, and neighbours, but that this is rarely the sole source of care (Hansen and Platz 1995, citied after Stuart and Weinrich 2001). If this figure would be true (60% of the 65 years old and older), than around half million people received informal help by relative or friends in 2007.

If older people receive help, then it takes the form of help with the home and garden, mostly provided by the children (64% in urban, 75% in rural area), the spouse (20%-13%) or other family members (12 %). Children provide mostly repair or transport services, while the spouse is mostly engaged in cleaning, shopping and gardening.

In general, family members do not regard themselves as caregivers to a large extent, they see themselves rather as having a social supportive role in relation to their older family members and practical tasks which they may help with are seen as a natural part of this supportive rather than caring role. Lewinter (1999) analysed the division of care work between the family members and the home-help services. She points out, that basic cleaning and personal care are the responsibility of the home help while other tasks are shared with the family members according to the individual situation. Mostly family members help the elderly remain socially active and included in the family or social networks (cited after Leeson 2004).

Whereas informal personal care giving is not common in Denmark, the government supports family care givers with specific measures which are fixed by law. The municipal council offers substitute or respite services to a spouse, parents or other close relatives caring for a person with impaired physical or mental function (CASS, Chapter 16, Section 84(1)). The municipality have to employ closely connected persons who are attached to the labour market, and who whish to care for a relative with substantial and permanent impairments of physical or mental function in the person's home if specific conditions are fulfilled. The carer may be employed for up to a continuous period of six months and receive a monthly salary of DKK 16,556. Furthermore, a person caring for a closely connected person who wish to die in his/her own home is entitled to a constant care allowance which amounts to 1.5 times of the sickness benefits to wish the recipient is entitled.

3.4 Demand and supply of formal care

Demand

One of the main aims of the social services for the elderly is to ensure that elderly people can stay in their own home for as long as possible in order to avoid institutionalisation. Thus, a great share of the recipients of permanent home help (206,600 in total) lived in their own home: around 165,700 people in 2007. Some 41,000 people received permanent home help in nursing homes or nursing dwellings (Table 2). Whereas people living in nursing homes receive personal care as well as help with practical duties, people living in their own home can receive only personal care or only help with practical duties or both kind of services. Around 44% of recipients living in their own home receive solely help with housework, 12% solely personal care (Table 3).

After the governmental structural reform, which takes place in 2007, information about the gender of care recipients exists, but only for 92 of the 98 new municipalities. According to this statistic around 69% of the recipients were women, among the elderly recipients around 72% (in 2008).

Recipients of permanent home help by age-groups

Although the assistance will be provided irrespective of the age of the recipients, the "need of care" occurs more often if people are growing older. Thus, a great part of the people receiving permanent home help was 65 years old and older. In 2007 179,000 elderly received permanent home help, among them 116,000 oldest old (80+) (Table 4). As a result around 21 % of the elderly in Denmark received long-term care in 2007. People in need for care not receiving home help or nursing care in an institution are rare. The comfortable situation can (among other things) be traced back to the fact, the every municipality has the obligation to offer each

citizen, who has turned 75 years old and live in their own home without personal or practical help, at least two preventive home visits every year. The visits were carried out by community nurses, who evaluate their needs and provides the necessary help to the elderly. In 2007 around 178,000 home visits were completed, but some 117,000 were refused by the elderly.

In total around 3.8 % of the population received practical and personal care by the municipalities in 2007, but the share of dependent people increases sharply with age (Table 5). The share of people receiving permanent home help amounts to less than 5% until the retirement age (65 years), but rises up to 21% for people aged 75 to 79, up to 37% for people aged 80 to 84, up to 60% for people aged 85 to 89 and up to 83% for people aged 90 years and older.

Compared to the share of beneficiaries of the long-term care insurance funds in Germany, a higher percentage of people in need for care received permanent home help in the single age-groups in Denmark. This can be traced back to the fact, that in Germany only people with substantial impairments in ADL (minimum: impairments in two activities) and additional in at least one IADL are entitled to receive benefits. In Denmark the eligibility criteria are more comprehensive (without minimum requirements). While in total 21% of the elderly (65+) received permanent home help in Denmark in 2007, only around 2% received personal care and 12% received both, personal care and help with practical duties. Thus, if we compare only those people who receive both, personal care and help with practical duties, in Denmark with the recipients in Germany, than the figures are similar (in particular in the older age-groups).

Recipients of permanent home help by duration of help

The broad definition of "need for assistance" lead to a high percentage of people receiving less than 2 hours permanent help per week. In 2007 around 50% of the elderly received up to 2 hours help, around 11% between 2 hours and less than 4 hours help, and another 11% between 4 hours and 8 hours of help (Table 6). There is a clear distinction in the duration of help provided between people living in their own home and people living in nursing homes or nursing dwellings. Recipients living in their own home receive on average fewer hours of help than people in nursing homes: 62% receive less than 2 hours of help per week and another 13% between 2 and 4 hours, while half of the people living in nursing homes receive 20 hours and more of care. Almost all beneficiaries receiving solely help with housework at home get less than 2 hours help per week (98% all ages, 99% of the elderly).

Only a small part of people living in their own home are in need of severe or very severe help. Around 3% of the elderly receive more than 20 hours of help. The share is a little bit higher for people receiving both kinds of care (personal and practical help). The proportion of people in need of intensive care in total recipients increases with age. Among recipients aged 90 and older 22% need intensive care.

People living in nursing homes and nursing dwellings

Beside the statistic of recipients of permanent home help, the statistics of clients in nursing homes and special dwellings for the elderly provides information about the characteristics of clients differentiated by living places. The two statistics are not fully comparable, but the latter provides additional information.

According to the clients statistics around 12,200 people lived in nursing homes, 2,200 in protected dwellings and 31,100 in nursing dwellings in 2007 (Table 7). Thus, the number of clients living in institutions or dwellings with around the clock services provided by permanent staff is a little bit higher than the number of recipients of permanent home help in nursing homes and nursing dwellings.

People living in nursing homes are on average older than people living in nursing dwellings: The share of people aged 90 and older living in nursing homes is 28%, but amounts to 24% in nursing dwellings (Table 8). Nevertheless, in both accommodations are nearly all clients 65 years old and older (95% respective 93%). Thus, 1.6 % of the population aged 65 years and older lived in nursing homes (and protected dwellings), and around 3.4% in nursing dwellings.

The number of people living in special dwellings for the elderly amounted to 39,500 in 2007, among them 32,700 people aged 65 years and older (general dwellings and other dwellings for the elderly). As the number of elderly (65+) receiving permanent home help at home (including dwellings for the elderly) amounts to 141.500 in 2007, the number of recipients living in their own home (without special dwellings for the elderly) can be estimated to be around 100.000, which are 57% of all elderly recipients.

Recipients living in their own home or in general dwellings are on average younger than people living in nursing homes or nursing dwellings. The share of people aged 90 and older is with 11% much lower than the share in nursing homes.

But also people in nursing homes do not always fulfil the common definition of care need. A study carried out by Ikegami et al. (1997) analyses the share of low-care cases in nursing homes. In Denmark 43 % of the included persons living in nursing homes in Copenhagen were classified as low-care cases. But the data stem from 1992 and in the meantime the situation may have changed caused by the deinstitutionalisation strategy.

Temporary home help

Temporary home help will be provided to people in special living situations, for example after hospitalisation. Temporary home help is indeed not a part of long-term care giving, but the figures are mentioned here to provide a complete picture of home help. In 2007 around 17,500 people received temporary home help for one period, and additional 4,300 people for two periods or more. Three out of four people receiving temporary help were in retirement age (65+).

Supply

Nursing homes

As permanent home help has a strict priority before care giving in nursing homes, no new nursing homes have been constructed since 1987 (Strandberg-Larsen et al. 2007). Thus, nursing homes are in the process of being phased out. Various forms of service-enriched housing are being developed in their place with the active support of the municipal and national governments. The goal is to create non-institutional, but supportive living arrangements for the elderly with varying levels of functioning. Such housing is often located near, and linked with

existing nursing homes, sheltered accommodation, day homes or day centres and/or community centres in order to maximize the use of personnel and facilities, as well as ensure convenient access to home help, home nursing, and other community services (WHO 2003).

As with home care services, it is the municipalities who determine if a citizen requires a kind of help that cannot be given in the private home. If a citizen is offered residential accommodation she or he can decide between the different alternatives in the municipality, or even more to another. Where a person wishes his/her spouse, cohabiting or registered partner to remain part of the household, the accommodation offered must be suitable for two persons. If the recipient dies, the surviving spouse or partner will be entitled to stay on. As of 1 January 2009, a care home guarantee are introduced, so that citizens eligible for nursing homes will have to wait no more than two months for a place to stay.

In 2006 there were around 91,000 places in homes suitable for the elderly, of these 45,000 included around the clock services from permanent staff. Around 15,400 places were provided in nursing homes in 2006 (Table 9). The number of places in nursing homes declined markedly in the last decades. In 1987 around 49,000 places in nursing homes exists, in 2001 27,600 and in 2006 15,400. In 2007 and 2008 a further reduction in places in nursing homes can be seen. On the other side the number of dwellings for the elderly increased from 3,300 in 1987, to 37,900 in 2001, and to 58,300 in 2006. This development reflects the changes in housing policy for the elderly.

Beside care giving in nursing home or at home, care giving in day care centres will be provided. In 2006 around 29,500 places in day care centres and day care homes for the elderly exists.

Home care services

Until the new law called “greater choice of provider” introduced in 2002, local municipalities were the only provider of home care for the elderly. The new law aims at securing elderly people, who receive home care services, the freedom to choose between different providers, the option of changing the help they receive from time to time and the possibility of moving to another municipality (with the entitlement). The municipalities have to calculate a unit price for home services and to invite private providers to compete for delivery. Private “for profit” providers of home care are gaining an increasing share of the market – some 600 private providers exists in 2006 – but they are mainly in the field of practical assistance, so the share of the total number of hours worked has remain below five percent (Goul Andersen, Carstensen 2009). Free choice is popular, and user satisfaction is slightly higher among those using private suppliers. Private providers can also compete by offering additional services against payment – an opportunity which municipalities do not have. But this has remained quite limited.

Public and private home care services provide personal care as well as help with practical duties. Often (public) home care services also provide nursing home care. In 2006 some 1.1million hours of assistance were provided by home services (Table 10). The greatest part of hours is provided for the combination of personal and practical assistance, around 0.93 million hours. Whereas the share of elderly (40 % of recipients) receiving solely practical help amounted to 44%, the provided number of hours amounts only to 60,500. Thus, the average hours per week provided for people receiving solely practical help was only 0.7 in 2006. On

average the number of hours delivered per week amounts to 5.4 hours for all persons receiving permanent home help. For people receiving both, personal and practical help, the delivered numbers of hours are with on average 9.24 much higher. The time spent to care giving and help is higher for the oldest old who receive both kinds of help (9.6 hours). Due to the financial pressure municipalities reduced the hours solely provided for help with practical duties in the past. In 1999 more than 12% of provided hours of assistance were solely help with housework, in 2006 only 5%. A shift to the provision of a combination of help takes place in the past. The share of hours provided for both (personal and practical assistance) increased from 77% in 1999 to 84% in 2006.

Employees in measures for the elderly

In total 100,000 people were employed in measures for elderly people in 2006 (full-time equivalent, see Table 10). Around half of them were home helpers, social and health workers (45.300) and more than one quarter were social and health assistants (26.300). Only 6.4% were engaged in nursing and another 2.5% in managerial nursing. Persons engaged for catering, cooking, kitchen help and cleaning amount to 8.500 full-time equivalents, which are 4.5% of the employees. Also persons for physiotherapy and pedagogical work are employed (around) 4.800 persons.

Between 2001 and 2006 the number of employees increased by 4.5% (4,300 full-time employees) driven by the ageing of the population (Statistical Yearbook 2009). Most of the additional employees were home helpers, social workers (2,900), but also the number of employees for Physiotherapy and pedagogical work show a dynamic expand.

4 LTC policy

4.1 Policy goals

The Danish welfare state has three primary characteristics: universalism, primarily tax-financed provision and single string provision. While the national government develops the legislative framework for social and health policies, the regional county authorities are responsible for health care services and the local authorities are in charge of most of the services close to the citizens, including long-term care to the elderly. The local self-government provides the foundation of the Danish welfare society. The goal is to provide care services to everyone in need for, general free of charge, independently from income, age or potential family caregivers. The aim is to help people to help themselves, i.e. local authorities provide services as supplementary assistance for tasks the person is unable to perform him- or herself (CASS, 16, 83). The local authority's decision about the provided level of care services must be based on an overall assessment of the applicant and must relate to the specific individual needs. The assistance shall be adapted from time to time to the actual specific needs of the recipient.

4.2 Integration policy

Following the administrative reform in Denmark in 2007, the primary sector is financed by the regions and local authorities. Medical assistance and hospital treatment are free of charge for patients, and between 25-60% of the costs of specialist health services (dentist, psychologists, chiropractors and physiotherapists) are also covered (Commission of the European Communities 2009). Local authorities are responsible for home nursing (offered free of charge on doctor's orders), and as of January 2007 also for some rehabilitation and health promotion and prevention. The secondary sector, consisting of hospitals, including psychiatric treatment, is operated by the fife new regions. The local authorities are responsible for providing the various forms of long-term care services. Denmark has the aim to integrate health and social care. The integrated health and social services implies that the services are provided to all elderly by integrated teams of home-helpers, home nurses etc (Colmorton, Clausen, Bengtsson, 2003). Therefore, Denmark has introduced a case management system. Each elderly in need of support has a case manager in the municipality, who is the individual counsellor of the older person applying support. The case manager coordinate the efforts and cancel when the elderly is hospitalised, on vacation or visiting relatives. Home nursing services, personal home care services and practical home care workers cooperate and coordinate their services. Many local authorities cooperate on measures of prevention and rehabilitation for the elderly, with the aim of enabling older people to remain in their homes for as long as possible. In addition, practical and personal assistance is supplied by local authorities, which employ physiotherapists or occupational therapists.

As regards discharges of older people from hospital, there are no regulations or standards to ensure coordination, although in some counties (before the local government reform) the hospitals and municipalities have reached their own agreements on coordination. Even though health and social care appears to be fairly well integrated at the municipal level the problems persist in coordination the activities of the municipalities and the counties (Colmorton, Clausen, Bengtsson 2003). The bulk of problems in terms of integration occur at the interface between the regionally administrated hospital system and the municipally administrated health and social care services.

4.3 Recent reforms and the current policy debate

The local government reform, which entered into force an 1 January 2007, established 98 new large local authorities (before 275) and five regions (before 16 counties). The reform has laid down the framework for strengthening local self-government. Principles for good decentralized management were agreed by the central government and the local authorities. The principles underline the right and duty of the local councils to take responsibility for determining and prioritising the service level, ensuring the quality of task management.

As regards major reforms, the Danish government has submitted a proposal for a quality reform to ensure renewal and development of the quality in old age sector (Council of Europe 2008). The reform means that the provision of care must be even more flexible than today and focus more strongly on the individual needs of the elderly. One way to achieve this is to spread positive experience more quickly and invest in a better physical framework. The government's preventive initiatives have to bee seen in this context. The objective is for as many

people as possible to have good conditions for a healthy, well-functioning and high-quality life. This will help to postpone the need for public assistance.

The initiative for quality reform includes also the intension to reduce the number of different assistants visiting the individual citizen. The aim is that recipients of home help services will be entitled to one permanent contact person who must be close to the citizen Furthermore, the local council's contract with the citizen must include clear and measurable objectives for the services areas, including home care. The aim is for citizens to get clear information about the service level they can expect in individual local authority service areas (Council of Europe 2008).

As part of the quality strategy, a quality fund is established, some funds of which will be given to improve the physical framework and introduce new technology, in particular labour force saving technology in old age care (NSR DK 2008). Additionally, an accreditation model will be tested that systematically supports staff's work with quality development through on-going learning by providing the opportunity to use experts as sounding boards.

Beside the quality reform the reduction of long waiting times for places in nursing homes or special dwelling for the elderly currently constitute a challenge. A care-home guarantee has been introduced with effect from 1. January 2009, under which older people with special needs for a dwelling in social housing or a care-home place must receive an offer of such accommodation at least two month after being accepted on the waiting list.

Another challenge is to increase the information about the possibility of free choice. As of 1 January 2003, Persons in need for care are entitled to choose between various home help providers (Ministry of the Interior and Health and Ministry of Social Affairs 2005). However, often people are unaware of these options. People with a comprehensive and permanent need for help due to reduced physical or mental functional capacity can obtain a cash subsidy to hire their own assistants in the form of citizen-managed personal assistance (CASS, 16, 95ff). The rules in this area have recently been changed to increase self-determination and flexibility in the schemes. Both citizens and case managers must have the necessary knowledge about the new option.

4.4 Critical appraisal of the LTC system

The demographic development of the proportionally increasing number of elderly people over the total population in Denmark is expected to pose serious challenge for municipalities. In order to reduce the financial costs of care for elderly people, health and social authorities are attempting to place more and more emphasis on self-care, and effective preventive and health promoting activities. The government and the local authorities agree to focus on the positive resource network that relatives represent for older and disabled people. The local authorities must therefore be aware of including the relatives and other relevant persons with a view to allowing them to assume responsibility (NSR DK 2008). However, it seems likely that patient co-payments and contracting services to private non-profit making agencies will become increasingly popular tools for reducing costs and raising revenue in the future (Strandberg-Larsen et al 2007).

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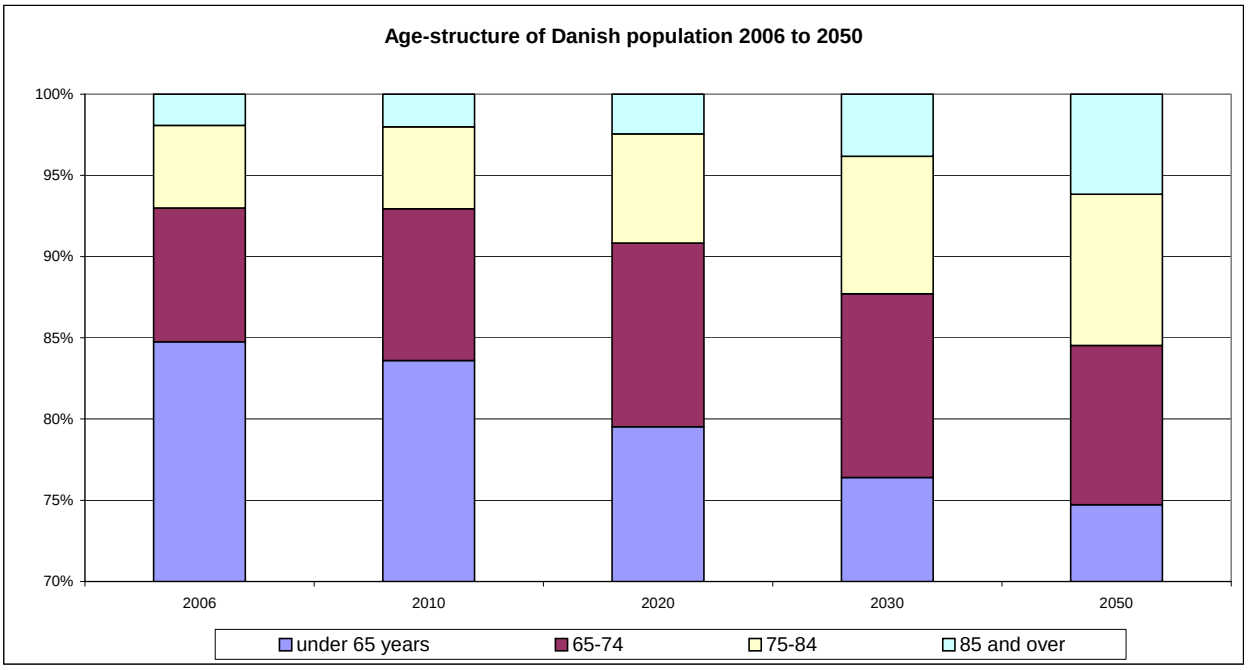
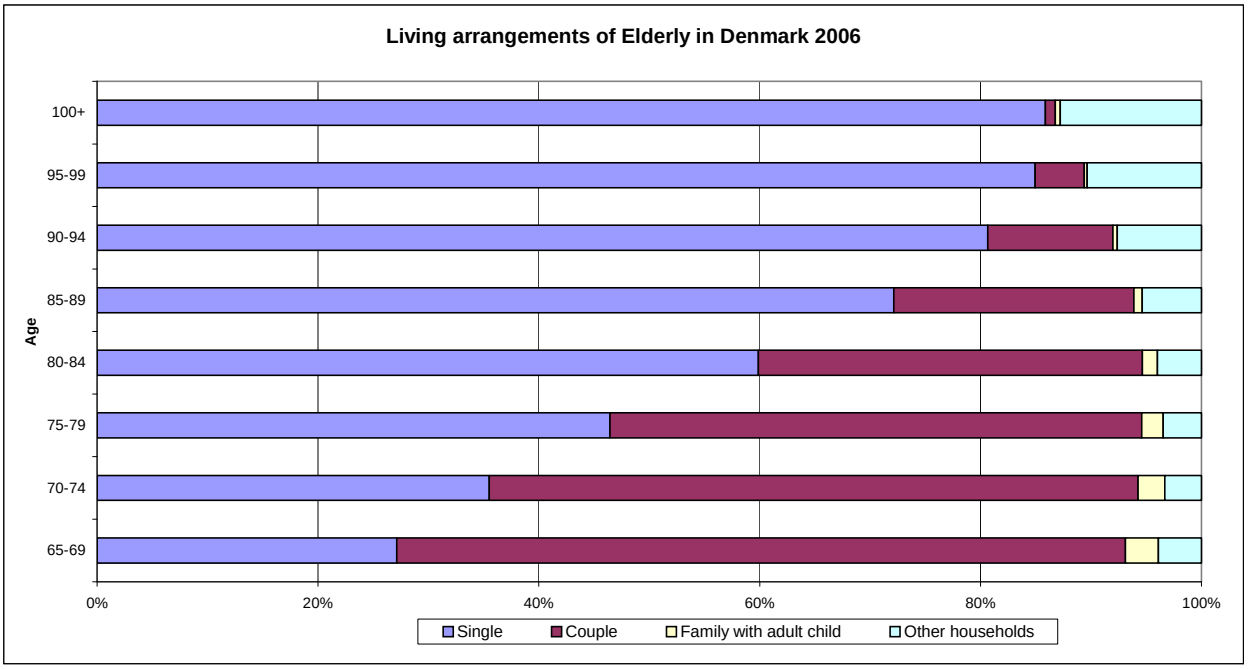
Figure 1
Age-structure of Danish population 2006 to 2050



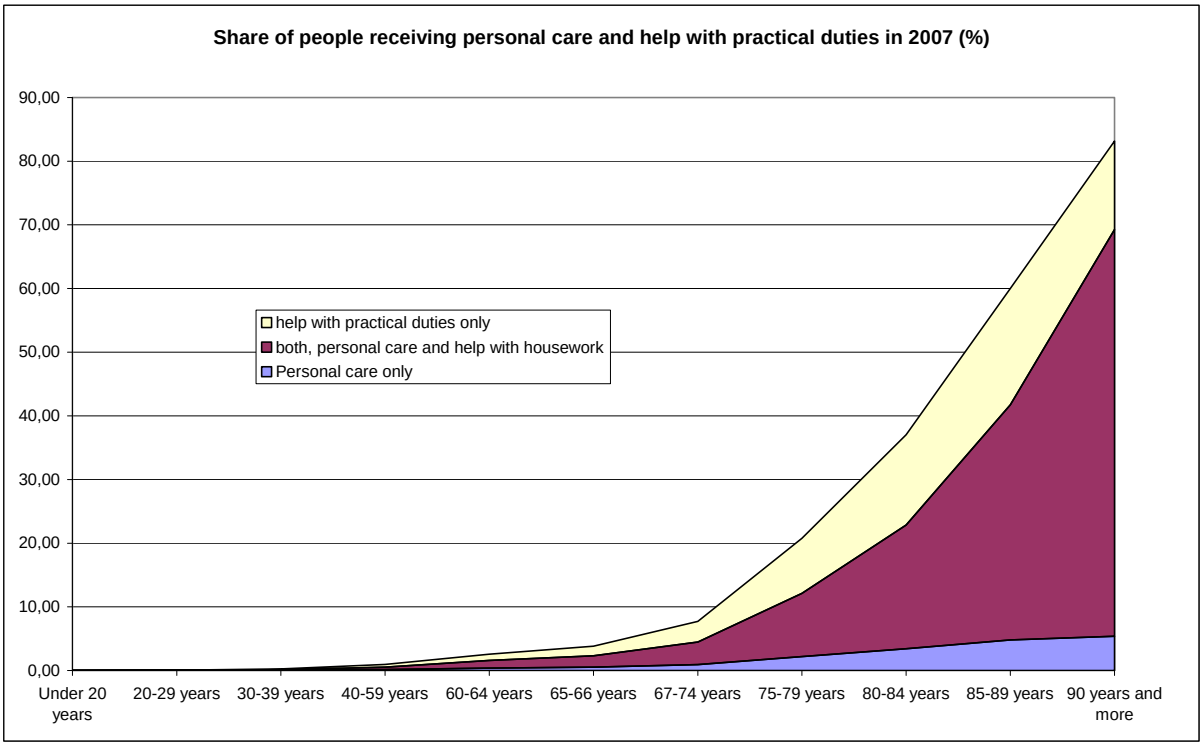
Source: Statistics Denmark, calculation by DIW Berlin.

Figure 2
Living arrangements of Elderly in Denmark 2006



Sources Statistics Denmark, calculation by DIW Berlin.

Figure 3
Share of people receiving personal care and help with practical duties in 2007 (%)



Sources Statistics Denmark, calculation by DIW Berlin.

Table 1
Social Expenditure for old age in Denmark 2005 in million DKK

	Social expenditure	Financing						
		Public authorities total	Of which Central Government	Employers (contribu-tions, premiums)	The insured (contribu-tions, special taxes)	Financing, other	Total columns 2., 4. and 5.	Transfer to and from funds (7.-1.)
	1.	2.	3.	4.	5.	6.	7.	8.
IV.a Old age								
1. Cash benefits								
A. Retirement pensions	112993	71571	70988	45371	17528	0	134469	21477
Of which								
a. Basic/minimum pension	71437	71437	71018	0	0	0	71437	0
b. Employment pension	6657	52	-113	4425	2467	0	6944	287
c. Supplementary pension	34899	82	82	40946	15061	0	56088	21189
B. Special retirement pensions	29093	3690	2005	-	25403	0	29093	0
C. Partial retirement pension	60	60	60	0	0	0	60	0
D. Other	24	24	0	0	0	0	24	0
Cash benefits, total	142170	75345	73053	45371	42931	0	163647	21477
2. Services								
A. Institutions, etc.	1856	1856	0	0	0	0	1856	0
B. Assistance to carry out daily tasks	25008	25008	3	0	0	0	25008	0
C. Other	1340	1340	101	0	0	0	1340	0
Services, total	28203	28203	104	0	0	0	28203	0
Total IVa.	170374	103548	73157	45371	42931	42350	191850	21477

Source: Social protection in the Nordic Countries 2006.

Table 2

People receiving permanent home help at home and in nursing homes and dwellings in Denmark in 2007

Age-groups	People receiving care and help	
	at own home*	in nursing homes and nursing dwellings
Age, total	165669	40959
Under 20 years	139	4
20-29 years	446	6
30-39 years	1803	78
40-59 years	13420	1327
60-64 years	8316	1191
65-66 years	3662	634
67-74 years	23057	3927
75-79 years	27433	5238
80-84 years	35830	8034
85-89 years	32371	10037
90 years and more	19192	10483
65+	141545	38353
80+	87393	28554

*) Including general and other dwellings for the elderly.
Source: Statistics Denmark.

Table 3

Recipients of permanent home help by kind of help in Denmark in 2007

Duration hours per week	Total	People receiving			
		only personal help	only practical help	both kinds of help	only personal help or both
	All age-groups				
Total duration	100	12,72	43,98	43,30	56,02
< 2 hours	100	11,18	69,14	19,68	30,86
2-3,9 hours	100	18,17	5,25	76,58	94,75
4-7,9 hours	100	14,31	0,50	85,19	99,50
8-11,9 hours	100	13,14	0,06	86,81	99,94
12-19,9 hours	100	12,18	0,10	87,73	99,90
>=20 hours	100	15,26	0,12	84,62	99,88
	Elderly (65+)				
Total duration	100	11,83	43,29	44,87	56,71
< 2 hours	100	10,49	69,17	20,34	30,83
2-3,9 hours	100	17,21	3,63	79,16	96,37
4-7,9 hours	100	13,18	0,28	86,54	99,72
8-11,9 hours	100	12,09	0,06	87,84	99,94
12-19,9 hours	100	10,37	0,08	89,55	99,92
>=20 hours	100	13,09	0,07	86,84	99,93

Source: Statistics Denmark.

Table 4

Number of recipients of permanent home help by age-groups in Denmark in 2007

Age-groups	People in need of care receiving				
	Permanent home help total	home help at home			in nursing homes
		help with practical duties only	Personal care only	both, personal care and help with practical duties	
Age, total	206628	72857	21070	71742	40959
Under 20 years	143	21	100	18	4
20-29 years	452	231	102	113	6
30-39 years	1881	1043	317	443	78
40-59 years	14747	6613	2366	4441	1327
60-64 years	9507	3668	1438	3210	1191
65-66 years	4296	1685	602	1375	634
67-74 years	26984	11298	3316	8443	3927
75-79 years	32671	13624	3468	10341	5238
80-84 years	43864	16792	4058	14980	8034
85-89 years	42408	12920	3384	16067	10037
90 years and more	29675	4962	1919	12311	10483
65+	179898	61281	16747	63517	38353
80+	115947	34674	9361	43358	28554

Source: Statistics Denmark.

Table 5

Share of people receiving personal care and help in population in Denmark 2007

Age-groups	People in need of care receiving			
	Permanent home help total	Personal care only	both, personal care and help with housework	help with practical duties only
	Share of people in need of care in population			
Age, total	3,78	0,39	2,06	1,33
Under 20 years	0,01	0,01	0,00	0,00
20-29 years	0,07	0,02	0,02	0,04
30-39 years	0,25	0,04	0,07	0,14
40-59 years	0,97	0,16	0,38	0,43
60-64 years	2,58	0,39	1,20	1,00
65-66 years	3,82	0,54	1,79	1,50
67-74 years	7,72	0,95	3,54	3,23
75-79 years	20,78	2,21	9,91	8,67
80-84 years	37,04	3,43	19,43	14,18
85-89 years	60,01	4,79	36,94	18,28
90 years and more	83,17	5,38	63,88	13,91
65+	21,32	1,98	12,07	7,26
80+	51,58	4,16	31,99	15,43

Table 6

Recipients of permanent home help by duration of help in Denmark in 2007

Duration hours per week	People receiving					
	permanent home help total	help at home total	only personal help	only practical help	both kinds of help	both kinds of help
	Total	Living in their own home				Living in nursing homes*
	All age-groups					
Total duration	100,00	100,00	100,00	100,00	100,00	100,00
< 2 hours	51,10	62,53	54,97	98,32	28,41	4,86
2-3,9 hours	11,16	12,74	18,20	1,52	22,53	4,79
4-7,9 hours	11,08	11,89	13,37	0,14	23,38	7,84
8-11,9 hours	6,35	5,44	5,61	0,01	10,90	10,07
12-19,9 hours	7,74	4,32	4,14	0,01	8,76	21,54
>=20 hours	12,56	3,08	3,70	0,01	6,02	50,90
	Elderly (65+)					
Total duration	100,00	100,00	100,00	100,00	100,00	100,00
< 2 hours	49,69	61,86	54,83	98,84	28,04	4,77
2-3,9 hours	10,95	12,64	18,39	1,06	22,30	4,72
4-7,9 hours	11,28	12,23	13,63	0,08	23,60	7,74
8-11,9 hours	6,66	5,73	5,86	0,01	11,22	10,07
12-19,9 hours	8,19	4,52	3,96	0,01	9,03	21,73
>=20 hours	13,23	3,01	3,33	0,00	5,82	50,96

*) Including nursing dwellings.

Source: Statistics Denmark.

Table 7

Clients in nursing homes and special dwellings for the elderly in Denmark in 2007

Age	Nursing homes	Protected dwellings	Nursing dwellings	Nursing together	General dwellings*	Other dwellings*	Dwellings together	Total
Under 60 years	306	222	1263	1791	2945	1723	4668	6459
60-64 years	334	115	932	1381	1475	587	2062	3443
65-66 years	190	46	515	751	790	284	1074	1825
67-74 years	1114	244	2970	4328	4530	1486	6016	10344
75-79 years	1443	268	3978	5689	4562	1495	6057	11746
80-84 years	2385	362	6403	9150	6027	1855	7882	17032
85-89 years	3091	504	7615	11210	5443	1678	7121	18331
90 and older	3372	481	7405	11258	3439	1135	4574	15832
Total	12235	2242	31081	45558	29211	10243	39454	85012
65 and over	11595	1905	28886	42386	24791	7933	32724	75110

*) For elderly persons.

Source: Statistics Denmark.

Table 8

Age-structure of clients in nursing homes and special dwellings for the elderly in Denmark in 2007

Age	Nursing homes	Protected dwellings	Nursing dwellings	Nursing together	General dwellings*	Other dwellings*	Dwellings together	Total
Under 60 years	2,50	9,90	4,06	3,93	10,08	16,82	11,83	7,60
60-64 years	2,73	5,13	3,00	3,03	5,05	5,73	5,23	4,05
65-66 years	1,55	2,05	1,66	1,65	2,70	2,77	2,72	2,15
67-74 years	9,11	10,88	9,56	9,50	15,51	14,51	15,25	12,17
75-79 years	11,79	11,95	12,80	12,49	15,62	14,60	15,35	13,82
80-84 years	19,49	16,15	20,60	20,08	20,63	18,11	19,98	20,03
85-89 years	25,26	22,48	24,50	24,61	18,63	16,38	18,05	21,56
90 and older	27,56	21,45	23,82	24,71	11,77	11,08	11,59	18,62
Total	100	100	100	100	100	100	100	100
65 and over	94,77	84,97	92,94	93,04	84,87	77,45	82,94	88,35

*) For elderly persons.

Source: Statistics Denmark.

Table 9

Places in nursing homes and dwellings for the elderly 2006 to 2008

Kind of home/dwelling	Places in nursing homes and dwellings		
	2006	2007	2008
Nursing homes	15424	12591	10470
Protected dwellings	2870	2202	2024
Nursing dwellings	32016	32249	34293
General dwellings for elderly persons	26276	29636	30173
Other dwellings for elderly persons	14846	10012	9288
Total	91432	86690	86248

Some municipalities report large deviations between dwellings from year to year and the coupilation is consequently less reliable. The number of dwellings and the number of persons cannot off-hand be compared, since they are compiled differently.

Table 10

Delivered hours of permanent home help per week in Denmark in 2006

Age-groups	People in need of care receiving			
	Permanent home help total	Personal care	both, personal care and help with housework	help with practical duties only
	Delivered hours of care and help per week			
Age, total	1.113.001	117.511	934.979	60.512
0-64 year	131.497	24.985	95.099	11.413
65-66 years	19.592	3.061	15.024	1.507
67-79 year	279.979	34.657	225.226	20.095
80 year and more	681.934	54.808	599.629	27.497
	People receiving care and help			
Age, total	206.886	20.716	101.181	84.989
0-64 year	28.675	4.185	10.758	13.732
65-66 years	4.283	598	1.699	1.986
67-79 year	62.506	6.763	26.196	29.547
80 year and more	111.422	9.170	62.528	39.724
	Delivered hours per week per person			
Age, total	5,38	5,67	9,24	0,71
0-64 year	4,59	5,97	8,84	0,83
65-66 years	4,57	5,12	8,84	0,76
67-79 year	4,48	5,12	8,60	0,68
80 year and more	6,12	5,98	9,59	0,69

Source: Statistics Denmark.

Table 11

Staff in measures for elderly people in Denmark in 2006 (full-time equivalent)

Function	Full-time equivalent
Total	99909
Management	447
Administrative work	1942
Ordinary office work	1857
Managerial nursing	2520
Nursing	6359
Physiotherapy etc.	3240
Pedagogical work	1527
Social and health care assistants etc.	26311
Home helpers, social and health workers etc.	45324
Catering and cooking of meals	4121
Cleaning and kitchen help	4367
Caretaker	1895

Source: Statistics Denmark.

ANCIEN

Assessing Needs of Care in European Nations

FP7 HEALTH-2007-3.2-2

Launched in January 2009, ANCIEN is a research project financed under the 7th EU Research Framework Programme. It runs for a 44-month period and involves 20 partners from EU member states. The project principally concerns the future of long-term care (LTC) for the elderly in Europe and addresses two questions in particular:

1) How will need, demand, supply and use of LTC develop?

2) How do different systems of LTC perform?

The project proceeds in consecutive steps of collecting and analysing information and projecting future scenarios on long term care needs, use, quality assurance and system performance. State-of-the-art demographic, epidemiologic and econometric modelling is used to interpret and project needs, supply and use of long-term care over future time periods for different LTC systems.

The project started with collecting information and data to portray long-term care in Europe (WP 1). After establishing a framework for individual country reports, including data templates, information was collected and typologies of LTC systems were created. The collected data will form the basis of estimates of actual and future long term care needs in selected countries (WP 2). WP 3 builds on the estimates of needs to characterise the response: the provision and determinants of formal and informal care across European long-term care systems. Special emphasis is put on identifying the impact of regulation on the choice of care and the supply of caregivers. WP 6 integrates the results of WPs 1, 2 and 3 using econometric micro and macro-modelling, translating the projected needs derived from WP2 into projected use by using the behavioral models developed in WP3, taking into account the availability and regulation of formal and informal care and the potential use of technological developments.

On the backbone of projected needs, provisions and use in European LTC systems, WP 4 addresses developing technology as a factor in the process of change occurring in long-term care. This project will work out general principles for coping with the role of evolving technology, considering the cultural, economic, regulatory and organisational conditions. WP 5 addresses quality assurance. Together with WP 1, WP 5 reviews the policies on LTC quality assurance and the quality indicators in the EU member states, and assesses strengths, weaknesses, opportunities and threats of the various quality assurance policies. Finally WP 7 analyses systems performance, identifying best practices and studying trade-offs between quality, accessibility and affordability.

The final result of all work packages is a comprehensive overview of the long term care systems of EU nations, a description and projection of needs, provision and use for selected countries combined with a description of systems, and of quality assurance and an analysis of systems performance. CEPS is responsible for administrative coordination and dissemination of the general results (WP 8 and 9). The Belgian Federal Planning Bureau (FPB) and the Netherlands Bureau for Economic Policy Analysis (CPB) are responsible for scientific coordination.

For more information, please visit the ANCIEN website (http://www.ancien-longtermcare.eu).